OFFICE OF THE INSPECTOR GENERAL FOR MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

Primary Inspection
Western State Hospital

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Inspector General

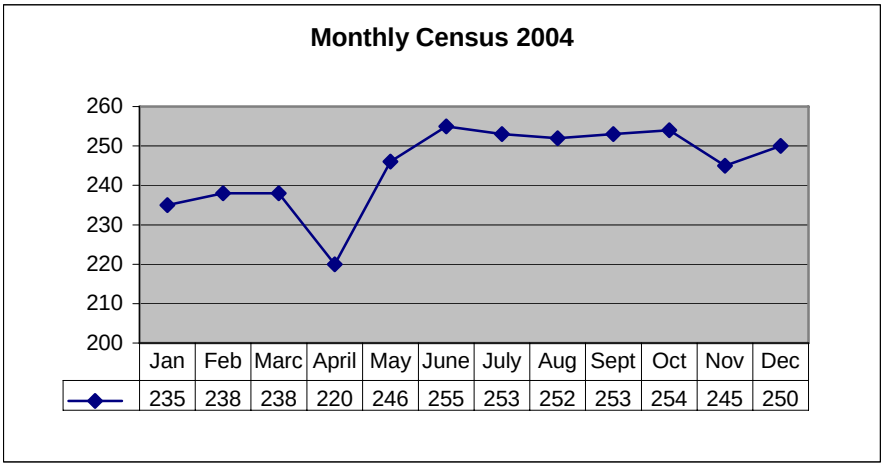
Report #111-05

WESTERN STATE HOSPITAL
STAUNTON, VIRGINIA
January 19-20, 2005
OIG Report #111-05

INTRODUCTION: The Office of the Inspector General (OIG) conducted a primary inspection at Western State Hospital (WSH) Staunton, Virginia during January 19-20, 2005. The inspection focused on a review of the facility through the application of 19 quality statements. These statements are grouped into 6 domains that include facility management, access to services, service provision, discharge, quality of the environment, and quality and accountability. The quality statements were formulated through interviews completed by the OIG with a number of stakeholder groups. These groups included the mental health facility directors, consumers, Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) central office administrative staff, DMHMRSAS Office of Mental Health Services staff and directors of mental health services for community services boards (CSB). The quality statements and the information obtained by the OIG through observations, interviews and a review of documents are described in this report. The report is divided into sections that focus on each of the domains previously noted.

SOURCES OF INFORMATION: Interviews were conducted with 38 members of the staff including administrative, clinical and direct care staff. Interviews were also completed with 14 consumers. Documentation reviewed included, but was not limited to, 7 clinical records, selected policies and procedures, staff training curricula, facility quality management plans, and risk management reviews. Tours were conducted.

BACKGROUND: WSH is one of seven mental health facilities operated by DMHMRSAS that provides services to adults between the ages of 18 and 64. The facility is the primary hospital for eight community services boards. The facility's operating capacity was reported as 254 beds. At the time of the inspection, the facility had a census of 239 consumers in-house with 9 additional consumers on pass from the facility. The census on the 1st day of each month during 2004 was as follows:



The approved budget for this facility in FY 2004 was $44,208,727 with reported expenses for the same period of $44,159,914. The facility reported that the budget for FY 2005 is $45,437,285. This represents an increase in funding from the actual expenses of the previous fiscal year of $1,277,371. The facility reported that the cost per bed day on June 30, 2004 was $503.89.

MENTAL HEALTH FACILITY QUALITY STATEMENTS

Facility Management

1. The facility has a mission statement and identified organizational values that are understood by staff.

The majority of staff interviewed was able to summarize the facility's mission. The written mission of the facility is as follows:

> *It is the mission of Western State Hospital to provide safe and effective individualized treatment. The mission is accomplished through:*
> - *Integrated medications, psychosocial rehabilitation, behavioral therapies and milieu supports;*
> - *Education of patients, families, students and employees; and*
> - *Operations that are within the framework of relevant laws, regulation, state budget appropriation, evolving professional standards, and sound ethical practices*

The direct care staff who were interviewed had difficulty identifying the facility's organizational values. Of the 18 direct care staff interviewed, 2 could not identify any of the values and 7 had a minimal awareness of them. Even though the staff were not able to verbalize the values, it was clear from the observations made by the OIG of staff/consumer interactions that staff are invested in providing the best care possible to the consumers. Interactions were characterized as supportive, positive, friendly and respectful.

The facility's values as outlined in the 2005 Strategic Plan included:

- Patient safety
- Teamwork
- Collaboration
- Honesty
- Empowerment
- Diversity
- Fairness
- Objectivity
- Continuous improvement

2. The facility has a strategic plan.

Interviews with administrative staff revealed that the Leadership Team at WSH has been in the process of implementing their 2005 strategic plan. The Leadership Team formulated the plan after conducting a S.W.O.T. analysis (strengths, weaknesses, opportunities and threats). The analysis was based on input from all the departments within the facility. The strategic plan has four primary goals which are:

- To maintain a viable workforce through the recruitment of additional nursing staff
- To maintain fiscal integrity
- To enhance the availability and quality of patient care and programming
- To improve organizational efficiencies particularly through technology

Administrative staff reported that the purpose of the strategic plan is to serve as a guide to the overall activities of the facility but noted that flexibility regarding its implementation is important as new initiatives or areas of focus are introduced. The strategic plan is communicated to staff through the supervisory process.

3. The mission and strategic plan have been reviewed and are linked to the recently adopted DMHMRSAS Vision Statement.

Administrative staff informed the OIG that the facility's mission and strategic plan have been reviewed in the context of the recently adopted DMHMRSAS Vision Statement. They qualified this, however, by explaining that WSH is only one component of a DMHMRSAS service delivery system for which the system Vision Statement is intended. They clarified that alignments in the area of recovery, self-determination and empowerment are understood to take place within the limits of the hospital setting where none of the consumers actively choose placement. These principles then are supported through a treatment process that proposes to assist consumers in being full partners in attaining real and sustainable change while hospitalized.

4. There are systems in place to monitor the effectiveness and efficiency of the facility.

According to administrative staff, creating an efficient and effective environment is the primary task of the facility's leadership team, beginning with fiscal accountability. One measure of efficiency that they monitor is cost per bed day as compared to similar settings. In addition, efficiency is measured through monitoring the average length of stay for consumers, the number of admissions and discharges and frequency of staff turnover.

Quality processes and corresponding outcome measures are developed facility-wide and within each professional discipline. Facility-wide measures are established in areas such as the use of seclusion and restraints or other restrictive procedures, the number of consumers that require the use of 1:1 staffing, and the number of falls and other areas of

potential patient injury. Medical, social work, psychology, and occupational therapy staff have quality review processes in place. Some methods of review include documentation checks, peer review of assessments and recommendations, and the use of practice guidelines.

Consumer satisfaction is also viewed as a measure of the facility's effectiveness. WSH conducts surveys with the consumers, families and/or legally authorized representatives (LAR) and the community services boards.

5. There are systems in place to assure that there is a sufficient number of qualified staff.

Data provided by the facility indicated that WSH has 810 approved full-time employee positions, of which 735 were funded at the time of the inspection. Of the funded positions, the equivalent of 706.23 were filled. Included in the full-time positions were 180 direct service associates (DSA), 40 psychiatric practical nurses (PPN) and 73 registered nurses (RN), including 2 clinical nurse specialists.

WSH staffing includes the following numbers of clinical staff:

- 18 psychiatrists, 3 internists and 3 physician extenders.
- 18 psychologists, 18 mental health workers and 8.5 assistant program managers in the psychology department
- 21 social workers, including the director.
- 4 occupational therapists (OT), 5 OT assistants, 3 recreational therapists, 1 music therapist, 1 vocational education specialist and 18 rehabilitation assistants
- 5 pharmacists, 5 pharmacy technicians and 1 radiology technician
- 1 dentist and 1 dental assistant
- 1 audiologist

Of the vacancies at WSH, registered nurse positions have been the hardest to fill. There were 22 RN and 2 PPN vacancies at the time of the inspection. The facility's strategic plan outlines two strategies for meeting the goal of recruiting and retaining nursing personnel.

The strategies include:

- Implementing the foreign nursing recruit program for DMHMRSAS
- Continuing to collaborate with Blue Ridge Community College in offering on-line and on-site educational opportunities for licensed nurses and direct care staff that want to pursue a nursing career
- Offering a more competitive salary

It was reported that the average salary for recently hired registered nurse positions was $45,026 and the average salary for direct care staff was $18,026.

Unit census and staffing numbers for registered nurse (RN), psychiatric practical nurse (PPN), and direct services associate (DSA) positions as observed by the OIG were as follows:

Evening Shift (January 19, 2005)

	STAFFING	CENSUS
Unit A5		
	1 RN, 1 Float RN, 1 PPN, 3 DSAs	23 consumers
Unit A6		
	1 RN, 1 Float RN, 1 PPN, 3 DSAs	21 consumers
Unit C1/2		
	1 RN, 1 PPN, 3.5 DSAs	20 consumers
Unit C 5/6		
	1 RN, 2 PPNs, 3 DSAs	20 consumers

Day Shift (January 20, 2005)

Admissions Unit (A1)		
	2 RNs, 1 PPN, 4 DSAs	24 consumers.
Admissions Unit (A2)		
	2 RNs; 1 PPN; 2 DSAs	24 consumers
Forensic Unit		
	2 RNs, 1 PPN, 5 DSAs	22 consumers
Building C 7/8		
	1 RN, 2 PPNs, 3 DSAs	23 consumers
Medical Unit (Acute)		
	1 RN, 1 PPN, 3 DSAs	16 consumers
Medical Unit (PSR)		
	1 RN, 1 PPN, 3 DSAs	20 consumers

On the dates of the inspection, the facility data indicated that there were 4 patients on a special observation status on the units toured.

All staff receive orientation and training specific to their positions within the facility. Direct care staff is involved in a three-week intensive training program that includes on-going review of knowledge and skills by immediate supervisors. Staff must be able to demonstrate competency in the key tasks they are expected to perform. Competency is verified either through written tests or "hands-on" demonstration.

6. There are mechanisms for direct care staff and clinical staff to participate in decision-making and planning activities.

Administrative staff reported that the primary mechanism for staff to engage in open dialogue regarding any aspect of care is through the ongoing supervisory process, unit meetings, rounds, treatment planning sessions and departmental meetings.

All of the direct care staff outlined ways in which they are able to participate in both unit specific and facility-wide decision-making and planning activities. Among those discussed were: monthly hospital-wide nursing meetings, unit staff meetings, through the treatment planning process and during supervision. Direct care staff also reported that the facility director meets with all the disciplines in the hospital to elicit feedback and to inform the staff of new initiatives or changes in procedures. It was also reported that the facility director sends out e-mails asking for suggestions and often visits the units to check in with staff.

Clinical and direct care staff reported that they are encouraged to participate on committees and performance improvement teams.

7. Facility leadership has a plan for creating an environment of care that values employees and assures that treatment of consumers is consistent with organizational values.

Administrative staff spoke of the formalized supervisor training that delineates approaches for assuring that employees are recognized in ways that are meaningful to them. This is based on supervisors taking the time to develop working relationships with the staff they supervise and getting to know them as individuals. Administrative staff stated that the modeling of respect, honesty and teamwork by supervisors in their dealings with the staff is the best way to communicate and assure that the treatment of consumers with the same values occurs. This was reported as particularly true when the modeling involves the expression of appreciation and the demonstration of valuing their efforts.

The leadership team talked about focusing efforts to create a learning culture that rewards employees for extraordinary performance. This approach also includes a fair review of areas of deficiency in performance with education regarding opportunities for learning and corrective action. The facility tries to stress this more constructive approach as opposed to a primary focus on punishment. Consumer incidents, complaints and identified areas of concern are reviewed for learning opportunities that can be shared with staff in order to prepare staff to handle situations that arise in the future. This information is repeated in a number of settings such as departmental meetings and director communiqués.

Sixteen of the 18 direct care staff interviewed provided examples of how staff feel valued by WSH. These included staff appreciation week, enhanced educational opportunities, RN of the month program and the small rewards offered by unit supervisors for a job well done. Several of the DSAs and PPNs reported sometimes feeling undervalued when they observe the rewards that are provided to RNs, such as greater scheduling flexibility, bonuses, and the RN of the month program.

WSH places a priority on consumer safety and this is reflected in the facility's effort to reduce the use of seclusion and restraints and to decrease other incidents that impact safety. Eleven of the 14 consumers interviewed reported that the staff are respectful,

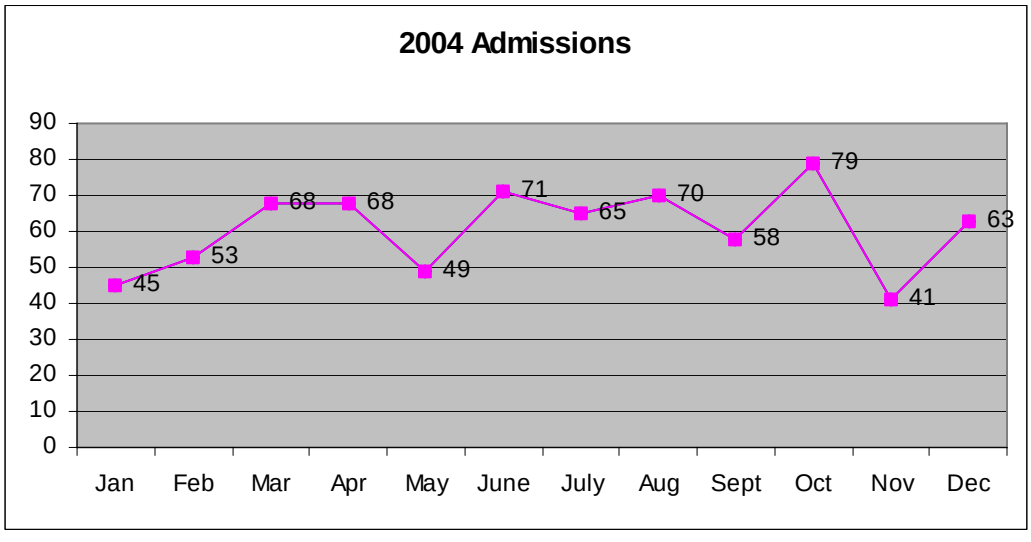
patient and caring. Interactions between the consumers and staff observed by the OIG during the inspection were positive. OIG staff spoke with a family member of a consumer who had been at the facility for over 10 years. The family member praised the efforts of the staff, reported always feeling welcome in the environment, and stated that staff work hard to accommodate visits. The family member was particularly appreciative of the unit social worker for helping to navigate an often-difficult healthcare system.

Access

1. There are systems in place to assure that those admitted to the facility are appropriate.

WSH serves adults between the ages of 18 and 64, who reside within the catchment area served by the following community services boards: Central Virginia, Harrisonburg-Rockingham, Northwestern, Rappahannock, Rappahannock-Rapidan, Region X, Rockbridge and Valley. The facility admits persons whose mental status and accompanying behavior pose significant threat of harm to self or to others. Admission occurs when there are no community-based alternatives available to provide the level of safety and care required as determined by a prescreener from the appropriate CSB. The Code of Virginia requires that a prescreener conduct an assessment before a consideration for admission can occur. Administrative staff reported that the programming offered at the facility is designed for persons with serious mental illness who present issues that are difficult to treat in a community setting. Often these individuals are not responsive to medications and other interventions and may display symptoms of serious behavioral discord, severe cognitive impairment and/or severe personality disorders. Of the 248 consumers in the facility on the first day of the inspection, 161 or 65% had a primary diagnosis of a schizophrenic disorder.

Data provided by the facility reported that there were 730 admissions to the facility during calendar year 2004. Of those admissions, 454 were male and 276 were female Monthly monitoring data for 2004 provided by the facility to the OIG reported the admissions as of the 1st day of each month as follows:



It was reported that the facility received 1,541 requests for admission during the same time period. This number excludes the requests made during the weekends, nights and holidays because this information is not captured by the facility.
The 3 primary reasons that admissions to the facility were denied included:

- The applicant was determined to be medically unstable and not suitable for admission
- The applicant had a primary diagnosis of substance abuse
- The applicant was a forensic consumer with extremely violent behavior

2. The facility works collaboratively with CSB's to assure access to appropriate services when admissions to the facility are inappropriate or not possible due to census.

Admissions and administrative staff outlined several ways the facility collaborates with the CSBs to assist in the placement of applicants who are determined to be inappropriate for hospitalization. Admissions staff and social workers are aware of a number of treatment options that may not be known to the community referral source primarily because of the larger geographic area the facility serves. The facility readily shares this information, including a primary contact person. When the facility is over census, admissions personnel will make the arrangements for the applicant to be admitted to a sister facility until a bed at WSH becomes available.

The OIG was informed that this collaborative relationship has evolved over time with the advent of the admission and discharge protocols and the establishment of regular meetings with community liaisons to discuss both problematic cases and the overall process.

Service Provision

1. There are systems in place to assure that the patient receives those services that are linked to his/her treatment needs and identified barriers to discharge.

Service provision at WSH includes the integration of psychotropic medications, psychosocial rehabilitation programming, behavioral treatment and the fostering of a positive and stable environment of care. All treatment was reported as designed to promote the type of symptom control and functional living skills necessary for the consumer to successfully reside in the community. There are discharge assistance programs to support and maximize each consumer's options for community placement and to overcome any barriers to discharge that are unrelated to the person's psychiatric condition, such as helping with the persons rent or purchasing a bus ticket.

Each person admitted to the facility undergoes a series of assessments by a number of disciplines. A nurse screening of both medical and psychiatric risks factors occurs within the first half-hour of the admission process. A complete physical examination and

psychiatric evaluation are completed within the first 24-hours. The majority of assessments are to be conducted prior to the formal treatment planning session, which occurs within seven days of admission. These assessments become the basis for developing the individualized treatment plan. Interviews with clinical staff indicated that treatment objectives are prioritized with a focus on those objectives that are related to "barriers" to the person re-entering the community. Consumers are active participants in identifying their treatment goals during the treatment planning process, including making choices for attending active treatment programming.

The OIG reviewed 7 consumer records. Each of the records contained a comprehensive individualized treatment plan. There was evidence that each plan was based on the integration of the assessments completed at the time of admission. Each record contained a problem list that included a listing of the behaviors that were identified as the barriers to discharge. Goals and objectives with corresponding treatment strategies were noted.

WSH operates several psychosocial rehabilitation (PSR) treatment malls that are designed to provide didactic and experiential opportunities for consumers. Group activities are offered Monday through Friday with leisure activities scheduled during the evenings and weekends.

In addition, the facility has initiated a project that enables treatment teams and PSR class leaders to assess the "fit" between classes offered and consumer needs. WSH uses the outcome of this assessment to redesign classes and to reassign consumers to achieve the best match.

The main treatment mall is located in the Stribling Building. This mall serves approximately 130 consumers daily. Interviews and a review of schedules revealed that there are approximately 15 groups offered during each 50-minute session held throughout the day. The curriculum for the mall is divided into 6 areas and each area has a Service Chief. Staff are posted in the hallways to monitor the milieu and to assist consumers as needed. The Stribling Mall environment resembles a community college setting. In addition to classrooms, there is a library, game room and a canteen. Canteen operations are supervised by a facility employee and managed by the consumers. In observing the operation of this mall area, it was evident that the consumers understood their responsibilities and readily fulfilled them. The supervisor provided the workers with enough detail to effectively complete their tasks and function on their own so as to enhance their skill level.

During the tour of the Stribling Mall, the OIG observed five sessions. These included Assertiveness in Relationships, Assertiveness in the Workplace, Interpersonal Relationships, Court Sports, Adolescent Education and Current Events. The consumers were actively engaged in each session. Interactions between the facilitators and the consumers were generally positive, respectful and friendly. The Barber Mall is a locked mall located in the same building. It is designed for individuals who need more supervision and structure. By creating this mall, the facility has provided a daytime

treatment space in which consumers who need to be contained can feel freedom to move about.

The First step Mall is located in C unit. It is set up primarily to provide programming for consumers with cognitive impairments that impact concentration, memory and attention span. The groups are held in a more confined area than the Stribling Mall, are more structured, are shorter in duration (usually 30 minutes) and have immediate reinforcers for attendance and participation.

There is a mall on the Deaf Unit, which is designed to address the unique treatment needs for the deaf and hard-of hearing. All of the facilitators are skilled in American Sign Language. Depending on their level of functioning, some deaf consumers attend sessions in the Stribling Mall with interpreters provided.

The Harvest Mall is a locked treatment mall for consumers in the acute admissions units and the forensic units. Administrative staff reported that there is not as wide an array of program offerings in this mall as in the Stribling Mall as sessions focus on areas relevant to the reasons consumers were admitted. Program offerings include topics such as stress management, nutrition and medication compliance. Each session in the Harvest Mall lasts approximately 40 minutes. OIG staff observed two sessions in the Harvest Mall. The facilitators engaged the consumers through activities and discussions. The OIG observed that treatment mall space in the Admission Building is very tight and limits programming.

2. There are processes in place that support evidence-based practices.

WSH has a number of processes in place that support evidence based practices. The medical staff monitors medication adherence and effectiveness. Unit psychiatrists provide the consumers and/or their LAR with the necessary information to make an informed decision regarding medication usage. The information provided includes the medication being recommended, the dosage, the benefits and the risks. Other medication monitors and outcome measures are established such as PRN usage, use of polypharmacy and the average number of medications prescribed at the time of discharge. Eight of the 10 consumers interviewed reported being fully informed regarding their medications. The other two stated they had been informed of their medications but not the risks and side effects associated with its usage.

Psychiatric practices designed to facilitate person-centered planning and recovery are monitored such as the consumers' satisfaction with psychosocial rehabilitation programming, the reduction of use of seclusion and restraint and consumer involvement in the treatment planning process.

3. The facility assures that service provision is grounded in the principles of recovery, self-determination and empowerment.

Those interviewed stated that the facility is actively seeking to incorporate recovery principles in all aspects of each person's care and treatment. Administrative staff stated that one component of PSR programming is to assist the consumer with developing a recovery action plan. This plan outlines activities, contacts, skills and precautions that the consumer needs to have in place in order to function within the community and to decrease the likelihood of rehospitalization. The plan then serves to guide the types of groups the consumer will benefit from participating in while hospitalized. Staff are trained in motivational interviewing, which is a technique used to assist consumers in thinking through identified areas of need. It empowers them to develop solutions for achieving personal goals. Clinical staff reported becoming more aware of the language of recovery in the last six months, which serves as a reminder to them that the consumer is an active and full partner in each stage of treatment and discharge. There was a noticeable contrast in the understanding of recovery principles between the clinical staff and the direct care staff interviewed. The direct care staff were not well versed in the principles of recovery. Most suggested that it probably had to do with assisting the consumers return to the community.

4. There are systems in place to measure the perceptions of consumers, families, direct care staff, clinical staff and administrative staff regarding the quality of the provision of care and services.

The OIG team was informed that consumer satisfaction with the active treatment programming is routinely surveyed. The information gathered is used to make changes in the types of groups offered and how the groups are conducted. There was a reported 80% response rate to these surveys. Other methods used to understand consumer and/or LAR satisfaction are through treatment team contacts and the discharge planning process.

Even though the administrative staff interviewed reported that the facility does not have a specific instrument for measuring the perceptions of staff, opportunities for them to share their perceptions are provided in supervisory meetings, team meetings, and direct access to the facility director.

Discharge

1. There are systems in place for effective utilization review and management.

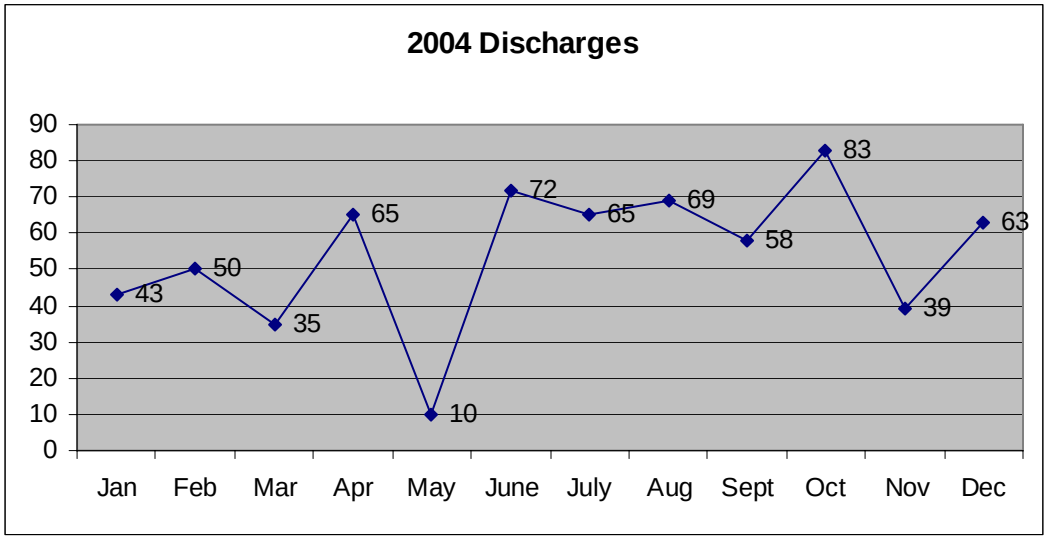
WSH has a utilization review and management process that focuses on these three areas:

- Management of admissions to the facility and bed day purchases from private psychiatric providers
- Clinical and utilization management of each consumer's course of treatment starting with the length of stay on the acute admissions unit
- Length of stay, including any identified barriers to discharge

There is a utilization review committee, which serves a review and advisory function to the census management committee.

Interviews with administrative staff indicated that social work staff begin the process of preparing the consumer for discharge at the time of admission, including establishing a targeted date for discharge. If the discharge has not been completed by the targeted date, the consumer's treatment team reviews the case with the community liaison to identify the areas that remain problematic and develop strategies for moving the discharge process forward. When hospitalization continues because of external placement issues, the consumer's name is placed on the extraordinary barriers list and referred to the facility's census management team for review and consultation. The committee makes recommendations for addressing the complex systems concerns through creative planning with the CSBs and other potential providers.

According to the monthly data provided to the OIG by the facility, there were 651 discharges in 2004. The following graph depicts the discharges during that timeframe.



2. There are systems in place to assure that effective communication occurs between the patient, facility and community liaisons regarding discharge readiness in order to assure a smooth transition of the patient into the community and to prevent re-hospitalization.

Social workers serve as the primary point of contact between the facility, the consumers, the LAR and the community. Interviews revealed that social workers from the facility maintain weekly contact with community liaisons to discuss cases and to review discharge readiness and plans. Information from these meetings is communicated to all parties involved including the consumer and potential treatment providers. Family members (as appropriate), LAR, and community liaisons are invited to participate in regularly scheduled treatment planning meetings during which discharge readiness and plans are explored. Contact increases, as the time of discharge gets closer. It is the primary responsibility of the facility in partnership with the consumer and/or the LAR to

determine the needs of the consumer upon discharge. This information is communicated to the community liaison who is responsible for facilitating the arrangements for service provision, housing and other identified service needs. The liaison also helps to make appointments with community providers. Crisis plans are developed for those persons identified as high risk for re-hospitalization. These plans are developed with the involvement of the consumer to determine strategies for securing supportive services within the community in the event of a situation that challenges that person's ability to safely remain in the community. Interviews revealed that effective discharge planning and established community linkages are the best mechanisms for preventing re-hospitalization.

Quality of the Environment

1. The physical environment is suitable to meet the individualized residential and treatment needs of the patients and is well maintained.

Services have been provided at the current Western State site since 1950. Since that time, there have been a number of changes in the nature of the population served and the treatment modalities employed. Buildings have been closed as the census has been reduced or converted to program space when appropriate. During the two-day inspection, the OIG toured 10 residential units and four treatment malls. Overall the residential units were clean and well maintained. Common rooms were neat and adequately furnished. Curtains were provided for both privacy and decoration. Efforts to make this very institutional setting appear more homelike were noted throughout the facility.

The acute medical unit was the only unit in the facility that utilized four person bed areas enclosed by half-walls, often referred to as pony walls. Staff indicated that the half-walls diminish the amount of privacy available for the consumers even though curtains are available to surround the bed areas as needed. Another drawback to the design is that there is only one light switch to control the lighting for one entire side of the unit, which makes it more difficult to respond to the individualized needs of the consumers.

The facility listed the following as the three most critical capital improvement projects that need to be addressed:

- Install sprinkler and fire alarm system in Building 102
- Campus-wide roof replacements
- Upgrade cook-chill rethermalization system

Projects involving the installation of the sprinkler and fire alarm system in Building 102 and the repair/replacement of steam lines are currently approved and funded at 1.25 million and .5 million dollars respectively.

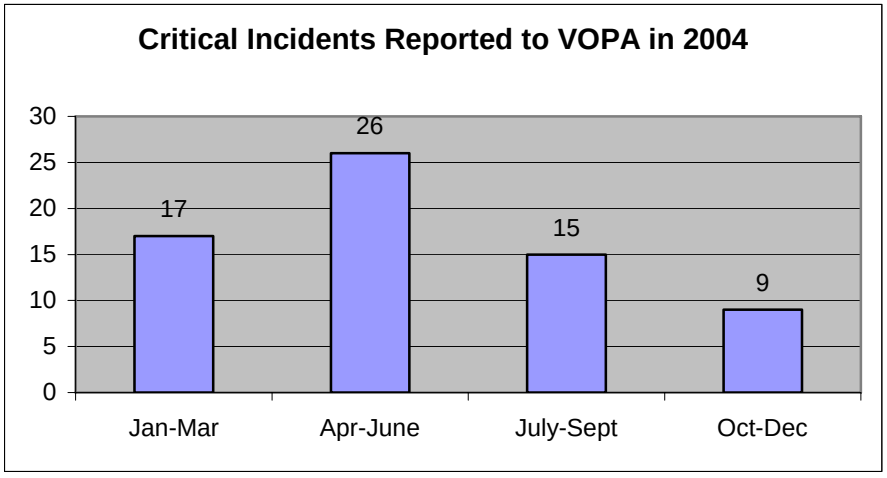
2. There are systems in place to assure that the environment of care is safe and that consumers are protected.

Safety of the consumers and staff was reported as one of the highest priorities of this facility. Safety is promoted through environmental checks, staff training, and the reporting systems established for identifying and monitoring serious incidents, formal/ informal complaints and allegations of abuse and neglect.

Building maintenance and safety checks are the joint responsibility of Buildings and Grounds and Campus Security. Routine rounds of all the buildings are made to assure that all equipment is in good working order and potential hazardous situations are dealt with before a problem develops. All staff are expected to report any areas that need repair or present a risk as soon as noted. Work orders are created and completed based on the levels of risk involved, with potential life, health and safety code violations attended to immediately.

Staff are trained in key areas that have a direct impact on consumer safety such as fire safety procedures, managing challenging and difficult consumers, medication risks and benefits, human rights and the reporting of allegations of abuse and neglect. The facility has a risk management program that identifies, evaluates and seeks to reduce the risks associated with injuries, property loss and other areas of liability. Data is tracked for trends regarding a number of key indicators such as patient injuries, patient related staff injuries, allegations of abuse and neglect, formal and informal complaints and incidents of seclusion and restraint usage.

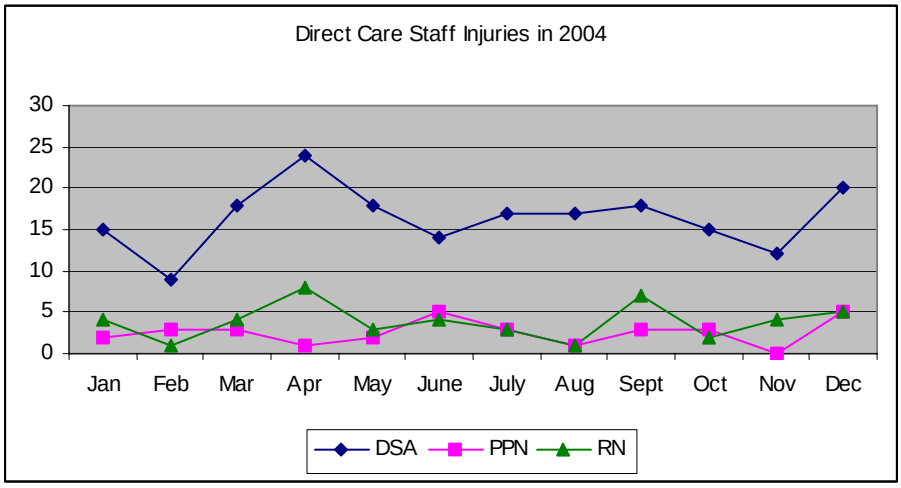
According to the information provided by the facility, there were 72 critical incidents at the facility in 2004. Of these, 67 meet the criteria for reporting to the Virginia Office of Protective and Advocacy (VOPA). The following graph shows the number of reportable incidents per quarter for 2004.



Information provided by the facility indicated that there were 375 staff injuries during 2004, of which 231 occurred during interventions with consumers. Injuries were either

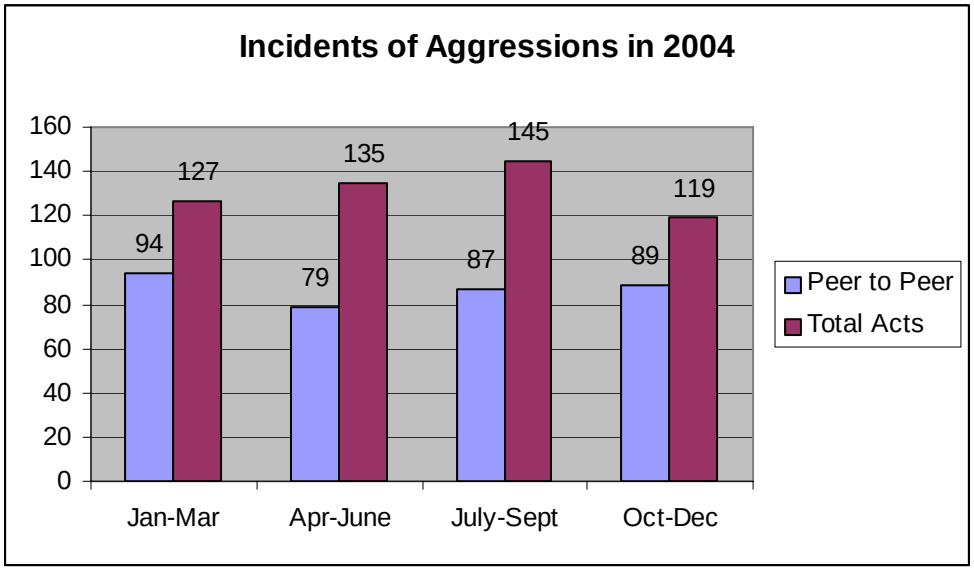
the result of aggression by the consumer or occurred while engaged in other consumer related activities, such as trying to prevent a consumer from falling.

Monthly data forwarded to the OIG from the facility recorded staff injuries for the direct care associates, psychiatric practical nurses and registered nurses. The following graph shows the number of incidents for each classification per month during 2004.

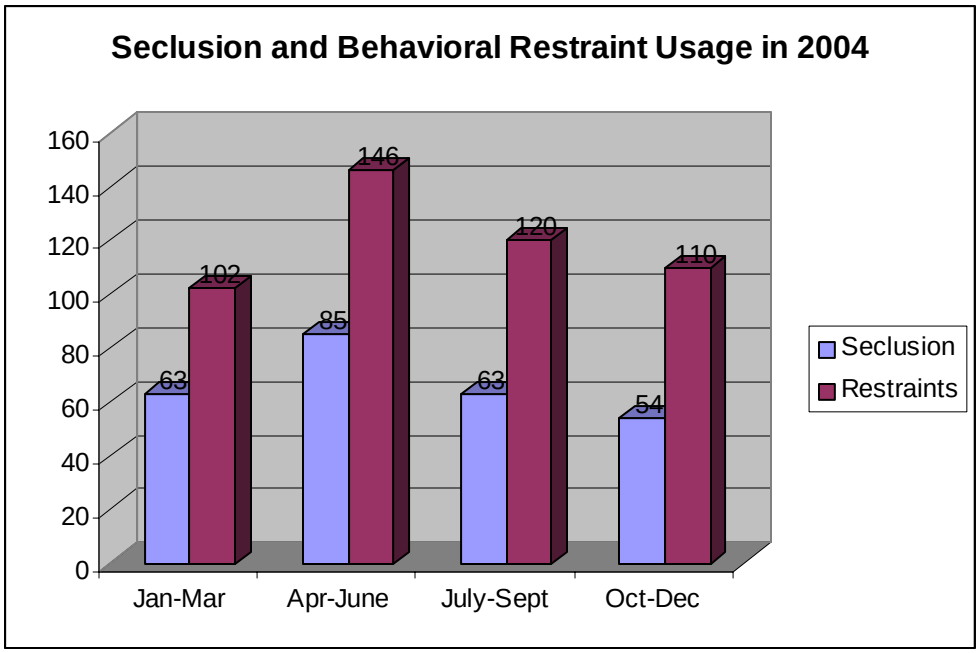


The data demonstrated that persons in direct care associate positions are more than three times likely to be injured than the other two classifications.

The facility recorded 526 incidents of aggressive acts during calendar year 2004. Three hundred forty-nine incidents involved peer-to-peer aggression.



There were 263 incidents that resulted in the use of seclusion and 478 incidents that resulted in the use of behavioral restraints during 2004. In addition, there were 439 incidents in which mechanical restraints were applied in the forensic unit at the facility. The restraints used with the forensic population were for transport purposes only.



All staff are provided training regarding human rights and the reporting of abuse and neglect. There were 15 allegations of abuse and neglect reported in 2004. Of those, 2 were substantiated. Consumers filed 204 informal complaints and 80 formal complaints during 2004.

When asked about the safety and maintenance of the environment of care, 15 of the 18 direct care staff stated that the facility did a good job in keeping the environment safe for both staff and consumers. Those interviewed outlined a number of ways in which this occurs. Their answers included: staff training, on-going facility safety checks by maintenance and security personnel, and staffing patterns that allow for adequate supervision of the consumers. Eleven of the 14 consumers interviewed reported feeling safe in the hospital setting. Two other consumers reported feeling safe most of the time except during times when they witness a disturbance on the unit or in the mall.

Quality and Accountability

1. There are systems in place to assure that the services provided from the time of admission to discharge are quality services.

WSH has a quality management program that is designed to establish a framework for improving the quality of consumer care at all levels within the facility. The quality management plan outlines that quality assurance activities are “planned, designed,

measured and assessed primarily within the context of the various disciplines and departments". The performance improvement activities underway at the time of the inspection included:

- A performance improvement team was established to review ways of improving the availability and condition of wheelchairs.
- A performance improvement team was established with a goal of improving the efficiency of the medication delivery system by reducing the time from the writing of the order to delivery to the pharmacy to actual filling of the prescription by pharmacy personnel.
- A performance improvement team was established with the goal of exploring ways to eliminate redundancy in the initial assessment process and evaluating the overall medical record regarding the workflow and how it can be improved.

Clinical staff interviews summarized quality care as completing thorough assessments, making an accurate diagnosis, developing excellent treatment plans that attend to adverse events, engaging the consumers in the process and facilitating timely and well planned discharge options for the consumers. Administrative staff pointed out that quality care is best achieved in an environment that fosters learning opportunities among the staff with prevention, not punishment, being the primary goal.

2. The facility has an accurate understanding of the stakeholders' perceptions regarding the services provided by the facility.

Satisfaction surveys are one of the tools used by WSH to determine the perceptions of the various stakeholders regarding the services provided by the facility. Surveys are conducted with consumers, families and the CSBs. On-going interactions with community providers and representatives from the CSBs allow for open dialogue regarding services and interagency working relationships.

Recommendations

The OIG has no facility specific recommendations for Western State Hospital as a result of this inspection. Based on the inspections of all 9 mental health hospitals and mental health institutes, a systemic review report will be issued in the near future that includes recommendations for all mental health facilities.